Wisconsin Department of Safety and Professional Services

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E-Mail: dsps@wisconsin.gov
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DENTISTRY EXAMINING BOARD

APPLICATION FOR DENTAL PERMIT TO ADMINISTER CONSCIOUS SEDATION

Under Wisconsin law, the Department must deny your application if you are liable for delinquent State Taxes or Child Support (Wis. Stats. § 440.12).

PLEASE TYPE OR PRINT IN INK

☐ Your name and address are available to the public. Check box to withhold street address/PO Box number from lists of 10 or more credential holders (Wis. Stat. § 440.14).

Last Name	**First Name**	**MI**	**Former / Maiden Name(s)**

Address (street, city, state, zip)

Daytime Telephone Number ___ - ___ - ____

Mailing Address (if different)

Date of Birth __ / __ / ____

Social Security # ___ - __ - ____

Your Social Security Number or Employer Identification Number must be submitted with your application on this form. If you do not have a Social Security Number, you must complete Form #1051. The Department may not disclose the Social Security Number collected except as authorized by law.

Ethnicity/gender status information is optional.

Ethnicity:
☐ White, not of Hispanic origin
☐ Black, not of Hispanic origin
☐ American Indian or Alaskan
☐ Asian or Pacific Islander
☐ Hispanic
☐ Other

Sex: ☐ M ☐ F

Email Address

List your Wisconsin Dentist Credential Number:

APPLICATION FEES: Please check applicable box. Make check payable to DSPS and attach to this application.

☐ **$ 75.00 Initial Credential Fee Attached**

For Receipting Use Only (15)

Committed to Equal Opportunity in Employment and Licensing

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CHECK THE BELOW CLASS FOR WHICH YOU ARE SEEKING CERTIFICATION (CLASS III, CLASS II OR CLASS I). Under each section is a list of documents required for certification. Your application will not be considered complete until the Department has received all documents.

☐ **CERTIFICATION FOR CLASS III/DEEP SEDATION AND GENERAL ANESTHESIA:** This permit allows a Dentist to do all of the following: deep sedation, general anesthesia, conscious sedation-parenteral, and conscious sedation-enteral. Dentists who hold Class III Permits do not have to obtain any other permit.

- ☐ Completed application (**Form #2759**)
- ☐ Fee attached to this application
- ☐ Proof of one of the following:
  - ►A Board-approved post-doctoral training program in the administration of deep sedation and general anesthesia (**Form #2758**).
    OR
  - ►A post-doctoral anesthesiology program in anesthesiology, which is approved by the Accreditation Council for Graduate Medical Education (**Form #2758**).
    OR
  - ►Minimum of one-year of advanced clinical training in anesthesiology (**Form #2758**).
    OR
  - ►Proof you have been utilizing general anesthesia for at least five (5) years prior to January 1, 2007 (**complete Class III Practice below**).
- ☐ Submit current copy of Advanced Cardiac Life Support Certificate (**front/back**).

NOTE: If the Dentist is a pediatric specialist, the Dentist may substitute proof of Certification in Pediatric Advanced Life Support.

CLASS III PRACTICE: Account for all activities and practice utilizing general anesthesia or deep sedation for the last five (5) years prior to January 1, 2007. **All** time and dates must be accounted for. (**Attach additional sheet, if necessary.**)

1. Location

Type of Anesthesia

Frequency (Ave. Use Per Week)

Dates (Month/Year)
(From) __/__
(To) __/__

Any Adverse Occurrences? ☐ Yes ☐ No (If yes, provide **Form #2764** for each occurrence.)

2. Location

Type of Anesthesia

Frequency (Ave. Use Per Week)

Dates (Month/Year)
(From) __/__
(To) __/__

Any Adverse Occurrences? ☐ Yes ☐ No (If yes, provide **Form #2764** for each occurrence.)

3. Location

Type of Anesthesia

Frequency (Ave. Use Per Week)

Dates (Month/Year)
(From) __/__
(To) __/__

Any Adverse Occurrences? ☐ Yes ☐ No (If yes, provide **Form #2764** for each occurrence.)

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4. Location

Dates (Month/Year)

(From) __/__

Type of Anesthesia

(To) __/__

Frequency (Ave. Use Per Week)

Any Adverse Occurrences? ☐ Yes ☐ No (If yes, provide **Form #2764** for each occurrence.)

5. Location

Dates (Month/Year)

(From) __/__

Type of Anesthesia

(To) __/__

Frequency (Ave. Use Per Week)

Any Adverse Occurrences? ☐ Yes ☐ No (If yes, provide **Form #2764** for each occurrence.)

☐ **CERTIFICATION FOR CLASS II/CONSCIOUS SEDATION - Parenteral:** This permit allows a Dentist to do the following: conscious sedation-parenteral and conscious sedation-enteral. Dentists who hold a Class II Permit do not have to obtain a Class I Permit.

- ☐ Completed application (**Form #2759**)
- ☐ Fee attached to this application
- ☐ Proof of one of the following:

  A Board-approved training course which includes (**Form #2758**):

  - ♦A minimum of 60 hours of didactic instruction which addresses the physical evaluation of patients, IV sedation, and emergency management
  - ♦20 clinical cases of managing parenteral routes of administration

  OR

  ►Graduate level training approved by the Board that at the minimum meets the above requirements (**Form # 2758**)

  OR

  ►Proof that the Dentist has administered conscious sedation-**parenterally** on an outpatient basis for five (5) years preceding January 1, 2007 (**complete Class II Practice below**)
- ☐ Submit current copy of Advanced Cardiac Life Support Certificate (**front/back**)

NOTE: If the Dentist is a pediatric specialist, the Dentist may substitute proof of Certification in Pediatric Advanced Life Support.

CLASS II PRACTICE: Account for all activities and practice for administering conscious sedation-**parenterally** on an outpatient basis for the last five (5) years preceding January 1, 2007. **All** time and dates must be accounted for (Attach additional sheet, if necessary.)

1. Location

Dates (Month/Year)

(From) __/__

Type of Anesthesia

(To) __/__

Frequency (Ave. Use Per Week)

Any Adverse Occurrences? ☐ Yes ☐ No (If yes, provide **Form #2764** for each occurrence.)

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CLASS II PRACTICE: (continued) Account for all activities and practice for administering conscious sedation-**parenterally** on an outpatient basis for the last five (5) years preceding January 1, 2007. **All** time and dates must be accounted for (Attach additional sheet, if necessary.)

2. Location

Dates (Month/Year)

(From) __/__

Type of Anesthesia

(To) __/__

Frequency (Ave. Use Per Week)

Any Adverse Occurrences? ☐ Yes ☐ No (If yes, provide **Form #2764** for each occurrence.)

3. Location

Dates (Month/Year)

(From) __/__

Type of Anesthesia

(To) __/__

Frequency (Ave. Use Per Week)

Any Adverse Occurrences? ☐ Yes ☐ No (If yes, provide **Form #2764** for each occurrence.)

4. Location

Dates (Month/Year)

(From) __/__

Type of Anesthesia

(To) __/__

Frequency (Ave. Use Per Week)

Any Adverse Occurrences? ☐ Yes ☐ No (If yes, provide **Form #2764** for each occurrence.)

5. Location

Dates (Month/Year)

(From) __/__

Type of Anesthesia

(To) __/__

Frequency (Ave. Use Per Week)

Any Adverse Occurrences? ☐ Yes ☐ No (If yes, provide **Form #2764** for each occurrence.)

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☐ **CERTIFICATION FOR CLASS I/CONSCIOUS SEDATION - Enteral:** This permit only allows a Dentist to do oral conscious sedation-enteral.

- ☐ Completed application (**Form #2759**)
- ☐ Fee attached to this application
- ☐ A Board-approved training course or graduate level training course that includes (**Form #2758**):
  - ►18 hours of didactic instruction which addresses physical evaluation of patients, conscious sedation-enteral, emergency management, and conforms to the principles in part one or part 3 of the American Dental Association's "Guidelines for Teaching the Comprehensive Control of Anxiety and Pain in Dentistry."
  - ►20 clinical cases using an enteral route of administration to achieve conscious sedation that may include group observation.
- ☐ Submit current copy of Basic Cardiac Life Support Certificate (**front and back**) and a Board-approved course in airway management.

  OR

  Submit copy of current Advanced Cardiac Life Support Certificate (**front and back**).

NOTE: If the Dentist is sedating patients age 14 or younger, the Dentist must provide proof of Certification in Pediatric Advanced Life Support.

No permit is required for anxiolysis or nitrous oxide inhalation. "Anxiolysis" means the use of medication to relieve anxiety before or during a dental procedure, which produces a minimally depressed level of consciousness, during which the patient's eyes are open and the patient retains the ability to maintain an airway independently and to respond appropriately to physical and verbal command.

CERTIFICATION OF LEGAL STATUS:

I declare under penalty of law that I am (check one):

- ☐ A citizen or national of the United States, or
- ☐ A qualified alien or nonimmigrant lawfully present in the United States who is eligible to receive this professional license or credential as defined in the Personal Responsibility and Work Opportunities Reconciliation Act of 1996, as codified in 8 U.S.C. §1601 et. Seq. (PRWORA). For questions concerning PRWORA status, please contact the U.S. Citizenship and Immigration Services in the Department of Homeland Security at 1-800-375-5283 or online at http://www.uscis.gov.

Should my legal status change during the application process or after a credential is granted, I understand that I must report this change to the Wisconsin Department of Safety and Professional Services immediately.

CONTINUING DUTY OF DISCLOSURE:

I understand that I have a continuing duty of disclosure during the application process. If information I have provided in this application becomes invalid, incorrect or outdated, I understand that I am obliged to provide any necessary information to ensure the information on my application remains current, valid, and truthful. I understand that Credentialing authorities may view acts of omission as dishonesty and that my duty of disclosure during the application process exists until licensure is granted or denied.

AFFIDAVIT OF APPLICANT:

I declare that I am the person referred to on this application and that all answers set forth are each and all strictly true in every respect. I understand that failure to provide requested information, making any materially false statement and/or giving any materially false information in connection with my application for a credential or for renewal or reinstatement of a credential may result in credential application processing delays; denial, revocation, suspension or limitation of my credential; or any combination thereof; or such other penalties as may be provided by law. I further understand that if I am issued a credential, or renewal, or reinstatement thereof, failure to comply with the statutes and/or administrative code provisions of the licensing authority will be cause of disciplinary action.

By signing below, I am signifying that I have read the above statements (Certification of Legal Status, Continuing Duty of Disclosure, and Affidavit of Applicant) and understand the obligation I have as an applicant or credential-holder should information I've provided to the Department of Safety and Professional Services change.

Signature: _____ Date: __ __ / __ __ / __ __ __ __